IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 11, 2003

Re: IRO Case # M2-03-1331

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

> History
> The patient is a 46-year-old female who on ___ backed into a table and immediately developed pain in her back. In two to three weeks she experienced some numbness into her right hand and spasms in her right arm, as well as continued back pain. On a 5/8/03 examination there was no reflex, sensory or motor deficit. Leg raising was positive bilaterally, but when the patient was sitting there was no pain response, indicating the potential of unreliable pain responses in general as far as indicating pathology. The records presented for this review indicate that there were no objective findings suggesting nerve pressure or other pathology. An MRI 4/4/03 showed an L-3-4 left-sided disk bulge, and to a lesser extent an L4-5 disk bulge. There was no herniation and nothing of surgical significance revealed. On 6/4/03 the patient said that the pain was in her neck, mid-back and low back. On another occasion the patient said that the pain was from her neck to her tailbone.

Requested Service(s)
MRI cervical spine, bone imaging tomogrphc

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
The patient's pain distribution is one that in my experience is never related to a correctable pathologic process. I cannot imagine anything that could be found on the requested studies that would lead to any therapy that would be of any benefit in treating this patient's problem.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to:
Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308(t)(2)).

Sincerely,

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 14th day of July 2003.